AdvaCare Clinics, Ltd
5325 W. 74th ST, Ste 9, Edina, MN 55439
Phone: 952-835-6653
Fax: 952-835-3895

Authorization for the Release of Protected Health Information

Name: _____ Date: _____

Date of Birth: _____ Gender: _____ SSN: _____ Phone: _____

Release Information From:

- ☐ AdvaCare Clinics
  5325 W. 74th ST, Ste 9
  Edina, MN 55439
- ☐ Other (Specify facility/individual & address below, including phone/fax if know.)
  _____
  _____
  _____

Release Information To:

- ☐ AdvaCare Clinics
  5325 W. 74th St, Ste 9
  Edina, MN 55439
- ☐ Other (Specify facility/individual & address below, including phone/fax if know.)
  _____
  _____
  _____

Purpose of Release

- ☐ Treatment/Continued Care
- ☐ Personal
- ☐ Other
- ☐ Legal Purposes
- ☐ Application for Insurance
- ☐ Payment of Insurance Claim
- ☐ Disability Determination

_____

_____

Information to be Released

Service Dates (Optional): from_____ to _____ Information Needed by (Optional): _____

- ☐ History and Physical
- ☐ EKG's
- ☐ Laboratory Reports
- ☐ Other
- ☐ Hospital Notes
- ☐ Immunization Records
- ☐ Pathology Reports
- ☐ Radiology Reports
- ☐ Hospital Discharge Report
- ☐ Clinical Notes
- ☐ Operative Reports
- ☐ Radiology Images
- ☐ Billing Information

_____

_____

I understand the information to be released may include records related to behavior and/or mental health care, alcohol and drug abuse treatment, HIV/AIDS, and genetics. This authorization may be revoked at any time except to the extent that action has been taken in reliance upon it. Revocation must be made in writing to the provider/facility releasing the information. The provider/facility will not condition treatment on whether I sign the authorization. **I may be charged for copies in accordance with state law.** Information used or disclosed pursuant to this authorization may be subject to redisclosure by the recipient and may no longer be protected by federal law.

This authorization will expire on year from the date of signing unless I indicate an earlier date or event here: _____

ATTENTION: This is a legal document. Please read carefully. By signing, you agree that you understand and accept the terms on this form.

- **If the patient is 18 years of age or older**, the patient must sign and date the form.
- **If the patient is 18 years of age or older and is incapable of signing**, a legally authorized substitute may sign and date the form.
  Please indicate your legal authority and include documentation of your relationship:
  - ☐ Legal Guardian or Conservator
  - ☐ Health Care Agent (Health Care Power of Attorney
- **If the patient is 17 years of age or younger**, the patient's parent or legal guardian must sign and date the form, unless an exception exists under state or federal law. Please indicate your relationship:
  - ☐ Parent
  - ☐ Legal Guardian

Signature: _____ Date Signed: _____

Printed Name of Person Signing (*If not patient*): _____

Mailing Address of Patient – Street: _____

City: _____ State: _____ Zip: _____ Phone: _____